STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155733	B. WING			04/14/2	011
		<u> </u>	D. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	8			NDIANA AVE		
COLONIA	AL NURSING HOM	E	CROWN POINT, IN46307				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCY)		DATE
F0000							
<u>'</u>	This visit was fo	or a Recertification and	F00	000	This plan of correction is to		
	State Licensure				serve as Colonial Nursing		
	State Dicensure	our vey.			Home's credible allegation o	f	
	C 1-4 A				compliance.		
	Survey dates. A	pril 11, 12, and 14, 2011					
					Submission of this plan of		
	Facility number:				correction does not constitu	te	
	Provider number				an admission by Colonial		
	AIM number:	100290370			Nursing Home or it's management company that t	ho	
					allegations contained in the	iie.	
	Survey team:				survey report are a true and		
	Sheila Sizemore	RN TC			accurate portrayal of the		
	Kelly Sizemore,				provision of nursing care an	d	
	Marcia Mital, Rl				other services in this facility		
					Nor does this submission		
	Regina Sanders,	KIN			constitute an agreement or		
					admission of the survey		
	Census bed type	:			allegations.		
	NF: 9						
	SNF/NF: 27						
	Total: 36						
	Census Payor ty	pe:					
	Medicare: 7	-					
	Medicaid: 27						
	Other: 2						
	Total: 36						
	101.1. 30						
	Commiss 10						
	Sample: 10						
	Supplemental: 4	ł					
		es reflect state findings					
	cited in accordar	nce with 410 IAC 16.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TZCE11

Facility ID:

If continuation sheet

TITLE

000360

STATEMEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155733	B. WIN			04/14/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
001.011		_		I	NDIANA AVE		
COLONIA	AL NURSING HOMI	Ē		CROW	N POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	Ouality review c	ompleted on April 19,					
	2011 by Bev Fau						
	2011 by Bev rau	iikiici, Kiv					
F0282		ided or arranged by the					
		ovided by qualified persons n each resident's written					
		n each resident's written					
CC-D	plan of care.	-4:	E0	202	F282 483.20(k)(3)(ii) SERVICE		05/14/2011
SS=D		ation, record review and	FU	282	BY QUALIFIED PERSONS PE		05/14/2011
	· ·	cility failed to ensure			CARE PLAN It is the practice		
	physician's order	s were followed, related			Colonial Nursing Home to prov		
	to medications, a	pressure ulcer			services by qualified persons i		
	intervention and	laboratory tests for 3 of			accordance with each resident		
		ewed for following			written plan of care. I. Resider		
		•			#22's heels are being off loade		
		in a sample of 10.			when in bed to relieve pressur	e.	
	(Residents #10, #	#22, and #27)			Upon realizing that the lab test	ts	
					for Resident #10 had not been	1	
	Findings include:				completed, the physician was		
	1 D :::1 : #10!				notified and the lab tests were		
		ecord was reviewed on			done. Resident #27 had no	41	
		m. The Resident's diagnoses			adverse effects from receiving		
		not limited to, hypothyroidism			antihypertensive medication. I All residents have the potentia		
	and cerebral palsy.				be affected. This is being	0	
	Δ Physician's order	dated 07/19/10, indicated to			addressed by the systems		
		s TSH (thyroid stimulating			described below. III. The facilit	t <b>v</b>	
		nyroxin) (laboratory tests of			has a policy regarding followin	•	
	the thyroid) in six w	- · · · · · · · · · · · · · · · · · · ·			resident's care plans. License		
	and districted in SIA W	2010, 00/20/10.			nurses have been re-educated		
	There was a lack of	documentation in the resident's			regarding this policy. A lab		
		e resident's laboratory test had			tracking tool has been		
	been completed on (	•			implemented to track to ensure		
	F				lab tests are being completed		
	During an interview	on 04/12/11 at 8:25 a.m., the			ordered. Licensed nurses hav	e	
		f Nursing indicated the			been inserviced on this		
		not been completed. She			procedure. An additional		
	-	mpany had not been notified of			inservice was conducted	the	
			1		regarding the need to monitor	ule	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155733	B. WING			04/14/2	011
			D. WIII		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER			l	NDIANA AVE		
COLONIA	AL NURSING HOM	Ē		l	N POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=D	4/11/11 at 11:20 diagnoses includ to, congestive he and chronic obstruction disease.  A MAR (Medication dated 4/1/11, indicated to the disease of the diseas	s record was reviewed on a.m. Resident #27's ed, but were not limited art failure, hypertension, ructive pulmonary  n Administration Record), ted Amlodipine Besylate lication) 2.5 mg (milligrams), every morning (hold if SBP sure] < (less than) 100). It was 14/6/11 at 9 a.m.			resident's blood pressure and administer the medication as ordered. Systemic changes a being monitored through our quality improvement program indicated. IV. The Director of Nursing or her designee is conducting quality improveme audits of the resident's overall plan of care. A random sample 3 residents are being checked weekly to ensure that labs are performed as ordered, that medications are given as prescribed including monitorin blood pressure, and that pressure place. These audits will contine weekly for 4 weeks; then everyother week for 4 weeks; then monthly for 6 months. Results all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.  F282 483.20(k)(3)(ii) SERVICE BY QUALIFIED PERSONS PECARE PLAN It is the practice Colonial Nursing Home to proservices by qualified persons accordance with each residen written plan of care. I. Residen #22's heels are being off loads when in bed to relieve pressur Upon realizing that the lab test for Resident #10 had not beer completed, the physician was notified and the lab tests were done. Resident #27 had no adverse effects from receiving	as nt e of gure inue y s of o SR of de n sht ed e.ts in the	05/14/2011
	minared as given on	4/0/11 at 9 a.m.			adverse effects from receiving antihypertensive medication. I		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MU A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPL <b>04/14/2</b> (	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  119 N INDIANA AVE  CROWN POINT, IN46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	4/6 the resident's ble During an interview on 4/12/11 at 9:05 a	og, dated 4/2011, indicated on bood pressure was 96/66.  with the MDS Coordinator, a.m., she indicated the blood in should have been held hat the order says.			All residents have the potential be affected. This is being addressed by the systems described below. III. The facilith has a policy regarding following resident's care plans. Licensed nurses have been re-educated regarding this policy. A lab tracking tool has been implemented to track to ensure lab tests are being completed ordered. Licensed nurses have been inserviced on this procedure. An additional inservice was conducted regarding the need to monitor resident's blood pressure and administer the medication as ordered. Systemic changes a being monitored through our quality improvement program indicated. IV. The Director of Nursing or her designee is conducting quality improveme audits of the resident's overall plan of care. A random sample 3 residents are being checked weekly to ensure that labs are performed as ordered, that medications are given as prescribed including monitorin blood pressure, and that pressulcer prevention strategies are place. These audits will continuely for 4 weeks; then even other week for 4 weeks; then even other weeks for 4 weeks; then even other week for 4 weeks; then even other weeks for 4 weeks; then even other	ty god ded de assert de as		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED
		155733	B. WING			04/14/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				NDIANA AVE	
COLONIA	AL NURSING HOME	=			N POINT, IN46307	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	( (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·				
SS=D		was observed on 4/11/11	F0.	282	F282 483.20(k)(3)(ii) SERVICE BY QUALIFIED PERSONS PE	
		ring on her back in bed			CARE PLAN It is the practice	
	sleeping. The res	ident's heels were not			Colonial Nursing Home to prov	
	floated off the ma	attress of the bed.			services by qualified persons i	
					accordance with each resident	
	Resident #22 was	s observed on 4/12/11 at			written plan of care. I. Residen	nt
		.m., and 10:00 a.m., in			#22's heels are being off loade	
	ĺ	it's heels were not floated			when in bed to relieve pressur	
	off the mattress of				Upon realizing that the lab test for Resident #10 had not been	
	on the mathess c	of the bed.			completed, the physician was	'
					notified and the lab tests were	
		cord was reviewed on			done. Resident #27 had no	
	4/11/11 at 11:30	a.m. Resident #22's			adverse effects from receiving	the
	diagnoses include	ed, but were not limited			antihypertensive medication.	l.
	to, cirrhosis of th	e liver, chronic renal			All residents have the potentia	l to
	failure, and cong	estive heart failure.			be affected. This is being	
					addressed by the systems	h.
	A Resident Asses	ssment Protocol			described below. III. The facilit has a policy regarding followin	-
		ort, dated 1/20/11,			resident's care plans. License	
	1	nt #22 was at risk for			nurses have been re-educated	
					regarding this policy. A lab	
	_	ue to her incontinence,			tracking tool has been	
	diagnoses and de	cline in mobility.			implemented to track to ensure	
					lab tests are being completed	
	A physician's ord	ler, dated 2/3/11,			ordered. Licensed nurses hav been inserviced on this	re
	indicated "Float l	heels while in bed."			procedure. An additional	
					inservice was conducted	
	During an intervi	iew on 4/12/11 at 10:00			regarding the need to monitor	the
	~	r of Nursing indicated the			resident's blood pressure and	
		vere not floated off the			administer the medication as	
	mattress.	Total not mouted on the			ordered. Systemic changes at	re
	mattiess.				being monitored through our quality improvement program	36
					indicated. IV. The Director of	ao
	3.1-35(g)(2)				Nursing or her designee is	
					conducting quality improvemen	nt
					audits of the resident's overall	
					plan of care. A random sample	e of

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/14/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE NDIANA AVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	must provide the resident with the necessary related to accomple of 10 reviewed for 10 reviewe	ordance with the ssessment and plan of care. servation, record interview, the d to ensure a n edema received y care and services e wraps (elastic eing applied as l resident in a n ecessary care in a total sample	F0309	3 residents are being checked weekly to ensure that labs are performed as ordered, that medications are given as prescribed including monitorin blood pressure, and that pressulcer prevention strategies are place. These audits will continue weekly for 4 weeks; then ever other week for 4 weeks; then monthly for 6 months. Results all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.  F309 483.25 PROVIDE CARE SERVICES FOR HIGHEST WELL BEING It is the practice Colonial Nursing Home to prothe necessary care and service to attain or maintain the highe practicable physical, mental, a psychosocial well-being, in accordance with the comprehensive assessment a plan of care. I. Resident #27 is receiving the ace wraps to legordered. II. All residents have potential to be affected. Residents with orders for ace wraps were reviewed to ensure the treatment is being applied. No concerns were noted. III. Licensed nurses were re-educated on the need to	g sure e in hue y so of co of vide ees st and of s s as e the re

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TZCE11

Facility ID: 000360

If continuation sheet

Page 6 of 30

			(X3) DATE SURVEY		
OF CORRECTION					04/14/2011
	100700	B. WIN		DDDRESS CITY STATE ZIP CODE	0 11 11 120 11
PROVIDER OR SUPPLIER			1		
AL NURSING HOME	≣		1		
			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
`			TAG		E COMPLETION DATE
Findings inc  Resident #27 reviewed on a.m. Reside included, but to, CHF (confailure), and  A nurses' non 8 a.m., indic (bilateral) L1 extremities) (swelling) non from toes to  A care plan, indicated "ed amount of ed for compress	lude:  7's record was 4/11/11 at 11:20 nt #27's diagnoses t were not limited ngestive heart pneumonia.  te, dated 4/10/11 at ated "B E'S (lower 3+ edema otedace wraps knees wrapped"  dated 3/20/11, demaassess demaace wraps sion to BLE		PREFIX	provide treatment as ordered, including ace wraps. Systemic changes are being monitored through our quality improveme program as indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits to ensure care is provided as necessary. Quality of care rounds are being completed. A random sample of residents will be audited to ensure that the necessary care being provided weekly for 4 weeks; then every other week 4 weeks; then monthly for 6 months. Results of all audits a being reported to the facility's of the surpersidents of the facility's of the surpersidents of all audits a being reported to the facility's of the surpersidents of all audits a being reported to the facility's of the surpersidents of all audits a being reported to the facility's of the surpersidents.	COMPLETION DATE  Completion  Date  Completion  Date
`	, ·				
`	•				
up) to thigh.	Apply in a.m.				
remove @ (a	at) 5 p & re-wrap				
	PROVIDER OR SUPPLIER AL NURSING HOME SUMMARY'S (EACH DEFICIENT REGULATORY OR Findings inc.  Resident #27 reviewed on a.m. Reside included, but to, CHF (confailure), and A nurses' not 8 a.m., indic (bilateral) Lile extremities) (swelling) not from toes to A care plan, indicated "examount of examount of exa	<b>I</b> '	PROVIDER OR SUPPLIER AL NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Findings include:  Resident #27's record was reviewed on 4/11/11 at 11:20 a.m. Resident #27's diagnoses included, but were not limited to, CHF (congestive heart failure), and pneumonia.  A nurses' note, dated 4/10/11 at 8 a.m., indicated "B (bilateral) LE'S (lower extremities) 3+ edema (swelling) notedace wraps from toes to knees wrapped"  A care plan, dated 3/20/11, indicated "edemaassess amount of edemaace wraps for compression to BLE (bilateral lower extremities) up (indicated by an arrow pointed up) to thigh. Apply in a.m.	DENTIFICATION NUMBER: 155733  A. BUILDING B. WING  PROVIDER OR SUPPLIER AL NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Findings include:  Resident #27's record was reviewed on 4/11/11 at 11:20 a.m. Resident #27's diagnoses included, but were not limited to, CHF (congestive heart failure), and pneumonia.  A nurses' note, dated 4/10/11 at 8 a.m., indicated "B (bilateral) LE'S (lower extremities) 3+ edema (swelling) notedace wraps from toes to knees wrapped"  A care plan, dated 3/20/11, indicated "edemaassess amount of edemaace wraps for compression to BLE (bilateral lower extremities) up (indicated by an arrow pointed up) to thigh. Apply in a.m.	DENOTICE OF CORRECTION    155733

000360

T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE COMPI 04/14/2	LETED
PROVIDER OR SUPPLIER		D. WINC	STREET A	NDIANA AVE N POINT, IN46307		
AL NURSING HOMING SUMMARY'S (EACH DEFICIEN REGULATORY OR Temove @ 1	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  0 p.m."  s order, dated ated to apply ace h legs up to the in the morning and re-wrap at 5 p.m., we at 10 p.m.  t's treatment d 4/11, indicated by were to be		STREET A	NDIANA AVE	E	(X5) COMPLETION DATE
wraps applie extremities.	ed to his lower					

000360

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL <b>04/14/2</b>	ETED
	PROVIDER OR SUPPLIER		11	19 N IN	DDRESS, CITY, STATE, ZIP CODE IDIANA AVE I POINT, IN46307	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Resident #2'	7 was observed on					
	4/11/11 at 1:	28 p.m., being					
		ed by CNA #1 and					
	LPN #2. CN						
	observed rer	_					
		ck from his right					
		ck left indentations					
		hen removed. The					
		ted the resident's					
		t a deep indentation The resident's legs n.					
	at 1:40 a.m.,	terview on 4/11/11 LPN #3 who was of resident #27,					
ı	_	e had not gotten to					
	the treatmen						
	3.1-37(a)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155733			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/14/2011
	PROVIDER OR SUPPLIER		119 N I	ADDRESS, CITY, STATE, ZIP CODE NDIANA AVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0314	a resident, the factor resident who enter pressure sores do sores unless the indemonstrates that and a resident have receives necessar promote healing, prevent new sores Based on obtreview, and facility failed preventative place to prevent for 1 of 10 repressure ulcomensure pressure ulcomensure pressures were 3 residents with the sore some as a sort of the sort of	servation, record interview, the d to ensure measures were in vent pressure ulcers esidents at risk for ers and failed to ure reduction ere in place for 1 of with pressure ulcers of 10. (Residents)	F0314	F314 483.25(c) PRESSURE SORES It is the practice of Colonial Nursing Home to ensthat a resident who enters the facility without pressure sores does not develop pressure so unless the clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receive necessary treatment and serv to promote healing, prevent infection and prevent new sor from developing. I. Resident # has the foam boots in place to both feet and heels are off loa when in bed to prevent furthe pressure. Resident #22's hee are being off loaded when in to relieve pressure. II. All residents have the potential to affected. This is being addres by the systems described belower that the systems described belower that the potential to affected. This is a policy regarding pressure ulcer	sure es cores es es vices es es #27 co aded r els bed co be esed
		#27's record was 4/11/11 at 11:20		prevention. Nursing personne were re-educated on this polic The CNAs are completing ski	cy.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SI COMPLE				
ANDILAN	OF CORRECTION	155733	A. BUII B. WIN			04/14/20	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	AL NURSING HOME			1	NDIANA AVE N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	N 1 OIN 1, IN 40307		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		nt #27's diagnoses			checks on shower days; the licensed nurses are document	ing	
	included, but	t were not limited			a weekly skin check to further assess for skin abnormalities.		
	to, CHF (cor	ngestive heart			Systemic changes are being		
	failure), and	pneumonia.			monitored through our quality improvement program as indicated. IV. The Director of		
		7 was observed			Nursing or her designee is conducting quality improvemen		
	sitting up in	his wheelchair			audits to ensure care is provid- as necessary. Quality of care	ed	
	with a sock of	on his right foot			rounds are being completed. A		
	and a foam b	poot to his left leg			random sample of 5 residents be audited to ensure that the	Will	
	on 4/11/11 a	t 11:18 a.m.,			necessary care including	_	
	12:04 p.m., a	and 1:15 p.m.			pressure reduction measures i being provided weekly for 4	5	
	The resident (Minimum II assessment, indicated the cognitive state impaired. The required extensions staff metals)	's admission MDS Data Set) dated 3/4/11, e resident's tus was severely the resident ensive assistance of mber for bed I the resident had			being provided weekly for 4 weeks; then every other week for 4 weeks; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.		
	A "Braden P Risk" assess	ressure Ulcer ment, dated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155733	A. BUI	LDING	00	COMPLETED 04/14/2011
		155755	B. WIN		ADDRESS SITV STATE ZIR CODE	04/14/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  NDIANA AVE	
COLONIA	AL NURSING HOMI	Ξ		1	N POINT, IN46307	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	2/28/11, indi	cated the resident				
had a total score of 18. The						
	form indicat	ed a score of 15-18				
	was at mild	risk to develop				
	pressure ulce	ers.				
	•	dated 3/1/11,				
	indicated "A	t risk for impaired				
	skin integrity	y r/t (related to)				
	impaired phy	ysical				
		nsure that all				
	ordered pres					
	•					
	_	lucing devices are				
	in placeflo	at heels (4/5/11)"				
	A physician'	s order, dated				
		ated "deep tissue				
		-				
	` • `	t) heel)wrap left				
	- `	ery day) c (with)				
	kerlixPodu	is boot (pressure				
	relieving dev	vice) to L LE				
	(lower extre	mity) @ (at) all X's				
		at R (right) heel				
	when in bed	` • /				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155733		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  04/14/2011		
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE NDIANA AVE N POINT, IN46307	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	A "Weekly V	Wound Evaluation					
	Flow Record	d", dated 4/5/11,					
	indicated the	e resident had an					
	unstagable p	ressure ulcer to his					
	left heel, wh	ich measured 4					
	centimeters	(cm) by 4 cm,					
	which was n	ecrotic (dead					
	tissue) and the	he surrounding					
	tissue was p	ink.					
	indicated "R suspected de L (left) heel. LLE (left lov (at) all X's	dated 4/5/11, es (resident) has eep tissue injury topodus boot to wer extremity) @Float B (Bilateral) in bedFoam boot all X's"					
	at 1:27 p.m., the resident Podus boot of indicated the	terview on 4/11/11 LPN #2 indicated did not have a on his left leg. She e foam boot he was a not the same as					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155733			LDING	NSTRUCTION  00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIEF		<b>-!</b>	119 N IN	DDRESS, CITY, STATE, ZIP CODE NDIANA AVE N POINT, IN46307	•	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG		oot he was wearing		TAG	DEFICIENCY)		DATE
	1 -	y when she worked.					
	Resident #2' 4/11/11 at 1: assisted to b LPN #2. Ch observed rer resident's so swollen right left indentat when remov pressure ulc resident's rig resident had wrapped aro LPN #2 indi had a new p right heel.  A "Weekly V Flow Record indicated the unstagable p	7 was observed on 28 p.m., being ed by CNA #1 and NA #1 was moving the					

000360

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE COMPI 04/14/2	LETED
	PROVIDER OR SUPPLIER		119 N II	ADDRESS, CITY, STATE, ZIP CODE NDIANA AVE N POINT, IN46307	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	centimeters	(cm) by 1.5 cm,				
	which was b	rown in color and				
	had a scab w	hich measured 0.2				
	cm by 0.5 cm	m in the center.				
	During an in	terview on 4/11/11				
	at 1:40 p.m.,	, LPN #3 indicated				
	the pressure	ulcer was a new				
	area.					
	at 1:53 p.m., coordinator changed the foam boot b	the MDS indicated they had podus boot to the ecause of the esident had in his				
	4/12/11 at 8: bed on his b heels were n	7 was observed on 256 a.m., lying in ack. The resident's ot elevated nor any foam boots on s feet.				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155733		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE SUI COMPLET	ED	
		155733	B. WIN		DDDEGG GITY STATE ZID CODE	04/14/201	1
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  NDIANA AVE		
COLONIA	AL NURSING HOME	E		1	N POINT, IN46307		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Resident #27	7 was observed on					
	4/12/11 at 8:	59 a.m., with LPN					
	#2 present, l	ying on his back in					
	the bed. LP	N #2 indicated the					
	resident's he	els were not					
	floated on a	pillow and the					
	foam boots v	were not in place.					
	LPN #2 then	applied the foam					
	boots to both	n feet.					
	During an in	terview on 4/12/11					
	at 9:05 a.m.,	the MDS					
	Coordinator	indicated she had					
	gotten the or	der yesterday to					
	change the p	odus boot to the					
	foam boots.	She indicated the					
	resident was	to have the foam					
	boots on bot	h feet at all times					
	except for sk	kin checks.					
	-						
	Resident #27	7's left heel was					
	observed on	9:22 a.m., with the					
		inator, the MDS					
	Coordinator	indicated the					
	resident's he	el was a deep					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155733		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR  A. BUILDING B. WING  (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR  COMPLETE  04/14/2011			ETED		
	PROVIDER OR SUPPLIER  AL NURSING HOME		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE  NDIANA AVE  N POINT, IN46307		
					N POINT, IN40307		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	tissue injury	and measured 4					
	cm by 4 cm	and was purple					
	black in cold	or with brown					
SS=D	edges.  2. Resident #22 at 11:20 a.m., lay sleeping. The resident floated off the matters of the mattress of t	was observed on 4/11/11 ring on her back in bed ident's heels were not attress of the bed.  s observed on 4/12/11 at .m., and 10:00 a.m., in at's heels were not floated of the bed.  coord was reviewed on a.m. Resident #22's ed, but were not limited at liver, chronic renal estive heart failure.  ssment Protocol ort, dated 1/20/11, at #22 was at risk for ue to her incontinence, accline in mobility.			F314 483.25(c) PRESSURE SORES It is the practice of Colonial Nursing Home to ensithat a resident who enters the facility without pressure sores does not develop pressure sor unless the clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receive necessary treatment and servito promote healing, prevent infection and prevent new sore from developing. I. Resident #1 has the foam boots in place to both feet and heels are off load when in bed to prevent further pressure. Resident #22's heel are being off loaded when in b to relieve pressure. II. All residents have the potential to affected. This is being address by the systems described belo III. The facility has a policy regarding pressure ulcer prevention. Nursing personne were re-educated on this policing results of the CNAs are completing skin checks on shower days; the licensed nurses are document a weekly skin check to further assess for skin abnormalities. Systemic changes are being monitored through our quality	es s ces es 27 ded ds ed be sed w.	05/14/2011
	resident's heels w	vere not floated off the			improvement program as		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	LE CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  04/14/2011	
		155733	B. WING		-   04/14/	2011
	PROVIDER OR SUPPLIER AL NURSING HOME		119	EET ADDRESS, CITY, STATE, ZIP COI ) N INDIANA AVE OWN POINT, IN46307	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION DATE
	mattress. 3.1-40(a) 3.1-40(a)(2)			indicated. IV. The Direct Nursing or her designee conducting quality impro audits to ensure care is as necessary. Quality or ounds are being complerandom sample of 5 resibe audited to ensure that necessary care including pressure reduction meaning provided weekly for weeks; then every other 4 weeks; then monthly for months. Results of all audieng reported to the fact Committee monthly for a recommendations where necessary.	e is  evement provided of care eted. A idents will at the g sures is or 4 r week for or 6 udits are cility's QA additional	
F0328	proper treatment a special services: Injections; Parenteral and en	ostomy, or ileostomy care; e;				
SS=D	interview, the factoxygen was admit the physician for for oxygen in a standard (Residents #13 and Findings include:	ation, record review, and cility failed to ensure inistered as ordered by 2 of 5 residents reviewed ample of 10 residents. and #27)	F0328	F328 483.25(k) SPECIA NEEDS It is the practice Colonial Nursing Home that residents receive pr treatment and care for s services. I. Resident #27 are receiving oxygen as by the physician. II. Res who utilize oxygen have checked to ensure that t correct oxygen liter flow on. III. Licensed nurses been re-educated on the	of to ensure coper pecial 7 & #13 ordered idents been the rate is have	05/14/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TZCE11

Facility ID:

000360

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155733		(X2) MULTIPLE CC  A. BUILDING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/14/2011	
	PROVIDER OR SUPPLIER		119 N II	ADDRESS, CITY, STATE, ZIP CODE  NDIANA AVE  N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
SS=D	Nursing indicated R oxygen at two liters observation of the reinterview, the reside oxygen on. The rate was set at three liter Nursing indicated at the oxygen was on a the oxygen rate on the oxygen rate on the oxygen rate on the oxygen. The Resident #13's record 2:50 p.m. The Resident's Physicated 04/11, indicated liters per minute.  2. Resident #27 at 11:18 a.m., 12 1:15 p.m., and 1: portable oxygen  During an intervipum., LPN #2 incording the portable oxygen	ician's Recapitulation Orders, ed an order for oxygen at two was observed on 4/11/11:04 p.m., 12:08 p.m.,		importance of following physics sorders regarding oxygen therapy. The correct oxygen rate has been added to the resident's care plan and the treatment administration record in addition the ordered oxygen flow rate is noted on the liquid portable tank as well as the in room concentrator. Nurses at checking the oxygen flow rate every shift to further ensure it correct. IV. The Director of Nursing or her designee is conducting quality improveme audits to ensure care is provid as ordered. Quality of care rounds are being completed. random sample of 5 residents be audited to ensure that the necessary care including oxygen therapy is being provided as ordered weekly for 4 weeks; the every other week for 4 weeks then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for addition recommendations where necessary.  F328 483.25(k) SPECIAL  NEEDS It is the practice of Colonial Nursing Home to ensure that residents receive proper treatment and care for special services. I. Resident #27 & #1 are receiving oxygen as order by the physician. II. Residents who utilize oxygen have been checked to ensure that the correct oxygen liter flow rate is on. III. Licensed nurses have	flow  rd. n  re is  is  ant ded  A  will gen hen is  anal  05/14/2011  sure  3 and

Facility ID:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULT A. BUILDI B. WING		00	(X3) DATE S COMPL <b>04/14/2</b>	ETED
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  119 N INDIANA AVE  CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	Ē	(X5) COMPLETION DATE
	saturation level (blood) which regis 92 to 100%). turn the portable liters. The resided 22 per minute. It tell the resident to LPN #2 then was resident's oxygen p.m. The resident level was 90%.  Resident #27's resident to the same statement was 90%.  Resident #27's resident to the same statement was 90%.  Resident #27's resident to the same statement was 90%.  A physician's tell 3/10/11 at 8:30 procession of the same plan for it dated 3/1/11, indicated 3/1/11, indicated 3/10/11 at 8:30 procession was same statement with the same statement was same same statement was same state	mpaired gas exchange, icated "4 liters			been re-educated on the importance of following physics orders regarding oxygen therapy. The correct oxygen frate has been added to the resident's care plan and the treatment administration recorn laddition the ordered oxyger flow rate is noted on the liquid portable tank as well as the in room concentrator. Nurses are checking the oxygen flow rate every shift to further ensure it correct. IV. The Director of Nursing or her designee is conducting quality improveme audits to ensure care is provided as ordered. Quality of care rounds are being completed. A random sample of 5 residents be audited to ensure that the necessary care including oxygen therapy is being provided as ordered weekly for 4 weeks; the monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for addition recommendations where necessary.	d. d. e is nt ed will en	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155733	B. WIN	G		04/14/2	011
COLONIA	ROVIDER OR SUPPLIER	<b>=</b>	STREET ADDRESS, CITY, STATE, ZIP CODE  119 N INDIANA AVE  CROWN POINT, IN46307				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0371	· '	• •					
SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  Based on observation and interview, the facility failed to distribute and serve food under sanitary conditions related to, dirty cups, plates, plastic container and cutting board, for 1 of 1 Kitchen. This had the potential to affect 35 of 36 residents who consumed food prepared in the kitchen out of a total population of 36.  Findings include:  During the initial tour on 4/11/11 from 9:42 a.m. through 10:00 a.m., with the Dietary Manager, the following was observed:  Kitchen:		F0	371	F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SA TARY It is the practice of Color Nursing Home to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, and prepare, distribute, and serve food under sanitary conditions All cups soaked and re-washe All identified plates soaked and re-washed Food debris on plastic containe cleaned Cutting board on bottom shelf cleaned, covered in plastic and moved to another location. II. All residents have the poten to be affected by deficient practice and the following corrective action has been tak III. A daily and weekly cleanin schedule will be followed with check off list initialed by responsible employee. Food	nial  I. d d er tial en. g	05/14/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733		(X2) MU  A. BUILI  B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPL <b>04/14/2</b>	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  119 N INDIANA AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
	to use plates with During an intervious observation, the lindicated she word.  3. The second shrefrigerator, had plastic container it.  4. A cutting boar.	all rewash them.  all, next to the a stored and ready to use that had food debris on  and stored and ready to m shelf next to the			Service Supervisor and cooks do daily checks of dishes and cups after all meals On April 1 2011 Food Service Supervisor held an in-service with dietary staff, this in-service covered Sanitation, storage and proper cleaning of dishes, cups, cuttir boards and all kitchen equipment. Food Service Supervisor is responsible for orientating any new hires on a aspects of dietary procedures. Dietary aides responsible for owashing with cooks and/or Food Service Supervisor will be responsible for cleanliness on a daily basis. I' Food Service Supervisor will be responsible for checking the entire kitchen daily for cleanliness. She will also chedaily and weekly cleaning schedule to assure assignmentare completed and disciplinary action taken for those failing to follow and/or document on forms. Forms will be maintain by Food Service Supervisor weekly and QA committee monthly on an ongoing basis.	4,	
F0425	residents, or obtai described in §483 facility may permit administer drugs it	rovide routine and and biologicals to its n them under an agreement .75(h) of this part. The unlicensed personnel to f State law permits, but only supervision of a licensed			menting on an ongoing basis.		
		vide pharmaceutical pprocedures that assure					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPLE		ETED		
		155733	B. WIN		<del></del>	04/14/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			l	NDIANA AVE		
COLONIA	AL NURSING HOMI	=			N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	•	TAG	DEFICIENCT)		DATE
	·	iring, receiving, dispensing, of all drugs and biologicals)					
	to meet the needs of each resident.						
	The facility must e	employ or obtain the					
		sed pharmacist who					
	provides consultat	tion on all aspects of the					
		nacy services in the facility.					
SS=D	Based on observa	ation, interview, and	F0	425	F425 483.60(a)(b)		05/14/2011
	record review, th	e facility failed to ensure			PHARMACEUTICAL SVC,		
	expired medicati	ons were discarded			ACCURATE PROCEDURES,	:_1	
	related to 1 of 1 i	nasal spray, 1 of 5 bottles			RPH It is the practice of Colon Nursing Home to provide routing		
of eye drops, 1 of 6 bottles of cough		1 3			and emergency drugs and	i i e	
		C			biological to its residents; and	to	
			provide services (including				
					procedures that assure the		
	of 2 medications	carts.			accurate acquiring, receiving,		
					dispensing, and administering		
	Findings include	:			all drugs and biological) to me		
					the needs of each resident. I. <sup>-</sup> eye drops, cough medication,		
	1. During an obs	ervation of the			laxative were disposed of and	anu	
	C-medication car	rt with LPN #2, on			new medications were ordered	d. II.	
	04/12/11 at 9:05	a.m., there was an			Medication carts were checked	d to	
	opened, non-date	-			ensure that there were no othe	er	
	Fluticasone nasa				out dated medications, or		
		an expiration date of			medications open beyond the		
					acceptable date. No concerns were discovered. III. Licensed	•	
		ottle of polyethylene			nurses were re-educated on th	ne	
	0 3 1	ith an expiration date of			facility policy regarding expired	-	
		le of robafen (cough			medications and dating of		
	syrup) with an ex	xpiration date of 11/10.			medications when opened.		
					Systemic changes are being		
	During an intervi	iew at the time of the			monitored through our quality		
	_	N #2 indicated the			improvement program as		
	,	e expired. She indicated			indicated. IV. The Director of Nursing or her designee is		
		check the medications			conducting quality improvemen	nt	
					audits of medications to check		
	and the Pharmac	ist comes and checks for			expiration dates and open date		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155733		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 04/14/2011	
	PROVIDER OR SUPPLIER		119 N II	ADDRESS, CITY, STATE, ZIP CODE NDIANA AVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
SS=D	2. During an obspass, on 4/12/11 took eye drops of LPN #4 indicate eye drops as ordowere opened 3/5 good for 29 days opened.  A facility policy, and Compromise 6/17/08, indicate	servation of a medication at 3:45 p.m., LPN #4 ut of the medication cart. d she couldn't give the ered due to the eye drops /11 and they are only after the eye drops are titled "Expiration Dates ed Medication", dated d "Eye drops, ear ll expire 28 days after		A random sample of 5 resident medications are being checked weekly for 4 weeks; then 5 residents will be checked ever other week for 4 weeks; then monthly for 6 months. The pharmacy consultant will assist monitoring during monthly factivists. Results of all audits are being reported to the facility's Committee monthly for addition recommendations where necessary  F425 483.60(a)(b)  PHARMACEUTICAL SVC, ACCURATE PROCEDURES, RPH It is the practice of Colon Nursing Home to provide routing and emergency drugs and biological to its residents; and provide services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering all drugs and biological) to me the needs of each resident. It eye drops, cough medication, laxative were disposed of and new medications were ordered. Medication carts were checked ensure that there were no other out dated medications, or medications open beyond the acceptable date. No concerns were discovered. III. Licensed nurses were re-educated on the facility policy regarding expired medications and dating of medications when opened. Systemic changes are being monitored through our quality improvement program as	d y st in lity e QA nal 05/14/2011 ial ne to of et The and d. II. d to er

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	A. BUIL B. WINC	DING	00 	COMPL 04/14/2	ETED
NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  119 N INDIANA AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0428	reviewed at least pharmacist.  The pharmacist mato the attending plants.	of each resident must be once a month by a licensed fust report any irregularities thysician, and the director of the reports must be acted			indicated. IV. The Director of Nursing or her designee is conducting quality improvemel audits of medications to check expiration dates and open date A random sample of 5 resident medications are being checked weekly for 4 weeks; then 5 residents will be checked ever other week for 4 weeks; then monthly for 6 months. The pharmacy consultant will assist monitoring during monthly fact visits. Results of all audits are being reported to the facility's of Committee monthly for addition recommendations where necessary	for es. ts d y t in lity	
SS=D	Based on record facility failed to recommendation a timely manner reviewed for pha in a sample of 10 Findings include  Resident #10's record 11:30 a.m. The Resident #10's record 11:30 a.m.	review and interview, the ensure pharmacy s were followed up on in for 1 of 10 Residents rmacy recommendations 0. (Resident #10)  :  rd was reviewed on 04/11/11 at ident's diagnoses included, but hypothyroidism and cerebral	F04	128	F428 483.60(c) DRUG REGIM REVIEW It is the practice of Colonial Nursing Home to ensithat the drug regimen of each resident is reviewed at least monthly by the licensed pharmacist. I. The pharmacy recommendations on Resident #10 have been reviewed by the physician. II. All residents clinic records have been reviewed to ensure that there are no other pharmacy recommendations the have not been addressed by the physician.III. Licensed nurses were re-educated on the facility.	t e cal o nat ne	05/14/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155733 04/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 119 N INDIANA AVE COLONIAL NURSING HOME CROWN POINT, IN46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE policy regarding pharmacy recommendations and A Pharmacy, "Potential Drug Interaction" form, the importance of timely follow dated 03/16/11, indicated the resident was through of the recommendation. receiving levothyroxine (thyroid medication) 125 Pharmacy has been requested to mcg (micrograms) and Calcium 500 mg send the "Potential Drug (milligram) with vitamin D 200 I.U. (international Interaction" forms to a secure fax units). The form indicated, "... The dosage of in the DON office. The DON or levothyroxine may need to be increased. her designee will then facilitate Separating the administration times of the process by submitting the levothyroxine and calcium carbonate may decrease forms to the attending physician the effects of the interaction...". instead of placing them in clinical record for a more prompt The Pharmacy, "Potential Drug Interaction" form, response. IV. The Director of dated 03/16/11, indicated, the resident was Nursing or her designee is receiving levothyroxine 125 mcg and ferrous conducting quality improvement sulfate (iron) 220 mg/5 ml (milliliter). The form audits of pharmacy indicated, "...The administration times of thyroid recommendations to check for agents and iron supplements should be separated timely follow through. A random by four hours..." sample of 5 residents will be audited to ensure that the The Pharmacy, "Potential Drug Interaction" form, necessary recommended dated 03/16/11, indicated, the resident was changes to the residents drug receiving Aspirin 81 mg and sertraline HCL regimes is being provided as (antidepressant) 100 mg. The form indicated, ordered weekly for 4 weeks; then "...should be used concurrently with caution. every other week for 4 weeks; Patients should be warned about the increased risk then monthly for 6 months. of bleeding..." Results of all audits are being reported to the facility's QA The Pharmacy, "Potential Drug Interaction" form, Committee monthly for additional dated 03/16/11, indicated the resident was recommendations where necessary. receiving ferrous sulfate 220 mg/ 5 ml and calcium 500 mg with vitamin D 200 I.U. The form indicated, "...Iron supplements should not be taken within 1 hour before or 2 hours after calcium..." The Resident's Medication Administration Records, Dated 03/11 and 04/11, indicated the Resident's aspirin, calcium ferrous sulfate, levothyroxine, and sertraline HCL were all scheduled to be given at 6 a.m.

Facility ID:

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE COME - 04/14/	LETED	
NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  119 N INDIANA AVE  CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
TAG	The Pharmacy, "Pot dated 03/16/11, indit the Physician on 03.  The Resident's recollevels were completed During an interview Assistant Director of Physician's orders worden the medications. The medications on 03/2 During an interview ADoN indicated the back and had ordered medication to be chausually follows up wif the Physician had recommendations.  During an interview the Director of Nursorder is not needed.	tential Drug Interaction" form, cated the form was faxed to /21/11.  Indicated the last thyroid and on 07/19/10.  In on 04/11/11 at 1 p.m., the of Nursing (ADoN) indicated a was needed to change the time. She indicated the Physician of the fax sent about the	TAG	DEFICIENCY)		DATE	

STATEMENT OF DEFICIENCIES		) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
		155733	B. WING		04/14/2011	
NAME OF F	AD CLUBER OR CLUBRUSER			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		119 N I	NDIANA AVE		
	AL NURSING HOMI			N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG	DEFICIENCE)	DATE	
F0458		neasure at least 80 square				
		n multiple resident least 100 square feet in				
SS=E	Based on observative record review, the provide the requiresident in 1 of 5 and for 6 of 19 m. The deficient prataffect 4 of 4 resident person rooms and one person rooms 201, 202, 204, ar. Findings include. Review of the far received from the 04/12/11 at 9 a.m. measurements of	ation, interview, and he facility failed to he facility resident rooms he facility level facility to he following he facility failed to he following he facility failed to he following he following single	F0458	F 458 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQUARE FT/RESIDENT It is the practice Colonial Nursing Home to pro- bedrooms that measure at lea 80 square feet per resident in multiple resident bedrooms, at at least 100 square feet in sing resident bedrooms. I. All affect rooms were measured and flo planned including furniture we completed for each room. II. A affected resident's conditions were reviewed for safety, com nursing care delivery, and priv to assure that there were no adverse effects to placement is rooms with square footage waivers. III. Prior to admission residents assessments will be reviewed to determine appropriate room assignment potential residents. Residents be assigned rooms by medica	vide st  nd gle ted or re All fort, racy n	
	*Room 111-1 (square) FT (feet	resident, 96.2 SQ		necessity and resident and far preference. IV. Residents conditions will be monitored by		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155733		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY  COMPLETED  04/14/2011			
NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME			B. WING 04/14/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  119 N INDIANA AVE  CROWN POINT, IN46307					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG	2. The floor area multiple resident *Room 101-2 SQ FT per letter *Room 201-1 FT, 74.5 SQ FT per letter *Room 202-1 FT, 72.0 SQ FT per letter *Room 204-1 FT, 72.0 SQ FT per letter *Room 204-1 FT, 72.0 SQ FT per letter *Room 204-1 FT, 70.5 SQ FT per letter *Room 206-1 Per letter *Room 101-2 bed Room 101-2 bed Room 104-2 bed Room 201-2 bed Room 201-2 bed Room 202-2 bed Room 204-2 bed Room 204-2 bed Room 204-2 bed Room 206-2 bed Room 101 had to waivers due to a	2 residents, 145.0 SQ FT, bed. NF no residents, 149.0 SQ per bed. NF no residents, 144.0 SQ per bed. NF no residents, 144.0 SQ per bed. NF no residents, 140.0 SQ per bed. NF no residents, 140.0 SQ per bed. NF ns with room variances n 04/12/11 at 9 a.m. The rooms were observed wing amount of beds: s ds ds ds ds		TAG	the Interdisciplinary Team dur Care Plan Conferences for appropriateness of room assignment. The Team will me recommendations to the Administrator/designee of a potential difficulty with room assignment. The residents new will be evaluated and if necessa room change will be initiate. Social Service will discuss root transfers with the resident and responsible party to arrange of smooth transition to a new root. The facility's QA Committee wassist as necessary.	eeds sary d. om d/or or a om.	DATE	

000360

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155733			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	(X3) DATE SURVEY COMPLETED 04/14/2011	
NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME			119 N II	ADDRESS, CITY, STATE, ZIP CO NDIANA AVE N POINT, IN46307	)DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
		room. She indicated the ters had not changed.					
	3.1-19(1)(2)						